DELAWARE HEALTH AND SOCIAL SERVICES
Division of Long Term Care Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

NAME OF FACILITY: Country Rest

DATE SURVEY COMPLETED: November 12, 2010

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey and complaint visit was conducted at this facility on November 8, 2010 through November 12, 2010. The census on the first day of survey was fifty-three (53). The deficiencies contained in this report are based on record review, observation, staff interviews and review of other facility documentation as indicated. The survey sampled totaled twelve (12) records, ten (10) active and two (2) closed records respectively.	
3201	Skilled and Intermediate Care Nursing Facilities Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference. §483.25 Quality of Care	

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	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for 2 (R#1 and R#3) out of 12 sampled residents the facility failed to follow the plan of care to monitor the effectiveness of pain medications. The facility failed to have a policy for pain management that met current standards of practice. Findings include: The pain management standards were approved by JCAHO in July 1999 and the same guidelines were approved by the American Geriatrics Society in April 2002 which included: - appropriate assessment and management of pain; assessment in a way that facilitates regular reassessment and follow-up; same quantitative pain assessment scales should be used for initial and follow up assessment; set standards for monitoring and intervention; and collect data to monitor the effectiveness and appropriateness of pain management.	

Provider's Signature Mark Yoder, Jr. Title Administrator Date Feb 2nd/2011

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	1. R1 was readmitted on 8/16/10 with diagnoses which included Stage IV pressure ulcer, prostate cancer, hypertension, chronic osteoarthritis, back pain with spinal stenosis and dementia. Physician orders dated 8/16/10 included oxycontin 20 mg BID (twice a day) for chronic pain, oxycodone IR 15 mg q 4 hours as needed (for pain) and neurontin 600 mg TID (three times at day) for back pain. The admission assessment dated 8/16/10 did not include a section to assess pain. There was no other comprehensive assessment of pain. A re-admission assessment dated 11/2/10 stated that the resident had pain to the buttocks and coccyx. There was no comprehensive assessment of the type, intensity and level of pain. The resident's care plan for pain included the approach to monitor for effectiveness of pain meds. Review of the MARs (medication administration records), nurses' notes and clinical record lacked evidence that R1 was assessed for the level of pain and the effectiveness of medications. Review of the August 2010 MAR revealed oxycodone 15 mg was administered 12 times. A pain scale was not used to evaluate the pain level before and after medication administration. On 5 out of 12	**§483.25** 1). A section to assess pain was added to the facility's Resident Assessment Form under Pain Management which will assess for the type, intensity and level of pain. This will be completed on admission, readmission and yearly for each resident. We also developed a policy for pain management to monitor the effectiveness of pain medications as follows: The MAR's will now include a section that requires nurses to assess or ask the resident if they have pain during the shift, using the pain scale for cognitively impaired, non-verbal residents and using the Wong-Baker FACES pain rating scale for resident with no cognitive deficit. If the resident is having pain, the nurse will follow the resident's care plan for proper interventions and document these interventions in the nurse's note and the back of the MAR. This policy was discussed at the nurses meeting on 1/24/2011. Please see attachment 1, 2, 3, 4. The DON will review the MAR's at the end of each month to ensure compliance with the policy.

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	opportunities the reason for the medication use was not documented and on 8 out of 12 opportunities the results were not documented. Review of the September 2010 MAR documented oxycodone 15 mg was administered 11 times. A pain scale was not used to evaluate the pain level before and after medication administration. The reason for the medication use was not documented for 3 out of 11 opportunities and on 9 out of 11 opportunities the results were not documented. Review of the October 2010 MAR documented oxycodone 15 mg was administered 7 times. A pain scale was not used to evaluate the pain level before and after medication administration. The reason for and the results of medication administration was not documented for 3 out of 7 opportunities. An interview with nurse E5 on 11/9/10 at 1:35 pm revealed that a pain scale was not used by the facility to evaluate pain. E5 stated that staff assessed pain when a resident tells them they are having pain. She further stated that when an as needed (PRN) pain medication is used the results should be documented on the back of the MAR. There was no system identified to evaluate pain management for residents with routine pain medications.	

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	The facility's policy documented that residents with diagnoses that would indicate pain or residents on pain medication would have a care plan to assess for pain. 2. R3 had diagnoses which included COPD, right CVA, osteoarthritis, dementia and atypical psychosis. The resident had a physician's order for Vicodin 5 mg/500mg every 8 hours around the clock. The only assessment found in the clinical record for pain was dated 3/2/09 and documented pain to the left side and back with fair intensity and interventions of vicodin bid and lidocaine cream. The resident had a care plan for chronic pain of the right shoulder and left knee that included the approach to monitor the effectiveness of pain medications. Evaluations of the care plan include the following documentation; 4/6/10 refuses lidocaine cream but c/o knee and shoulder pain frequently will ask MD to re-evaluate meds, 6/1/10 refuses lidocaine frequently still c/o pain on movement of knee, 7/30/10 refusing lidocaine changed to as needed has new c/o pain right hip x-ray showed osteoarthritis, and 10/5/10 knee painful to touch only refuses lidocaine cream. There was no evidence that the facility had a system in place to assess R3's	**§483.25** 2). A section to assess pain was added to the facility's Resident Assessment Form under Pain Management which will assess for the type, intensity and level of pain. This will be completed on admission, readmission and yearly for each resident. We also developed a policy for pain management to monitor the effectiveness of pain medications as follows: The MAR's will now include a section that requires nurses to assess or ask the resident if they have pain during the shift, using the pain scale for cognitively impaired, non-verbal residents and using the Wong-Baker FACES pain rating scale for resident with no cognitive deficit. If the resident is having pain, the nurse will follow the resident's care plan for proper *interventions and document these interventions in* the nurse's note and the back of the MAR. This policy was discussed at the nurses meeting on 1/24/2011. Please see attachment 1, 2, 3, 4. The DON will review the MAR's at the end of each month to ensure compliance with the policy.

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	level of pain and effectiveness of the pain medication. An interview with the DON E2 on 11/9/10 revealed that staff has had in-service training on how to assess for and document pain management. **§483.25(c) Pressure Sores** **Based on the comprehensive Assessment of a resident, the facility must ensure that—** **(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and** **(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.** **This requirement was not met as evidenced by:** Based on clinical record review and interview it was determined that for 3 (R2, R4, R1) out of 12 residents sampled the facility failed to provide the necessary services for assessing, measuring and documenting the assessments of pressure ulcers. Findings include: Facility's policy and procedures for "Documentation of Open Skin Areas"	

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	stated "classification –by stage Pressure ulcer...Anatomical location. Size (there were no instructions on how to measure the size of the wound)... Surrounding tissue or 'Peri-wound' observe for color and temperature... Note if skin is intact, open, moist or weepy....". 1. Review of R2's clinical record and wound sheet revealed R2 was assessed with a sacral wound "1 cm x1/2 cm x ½ cm" on 8/18/10. There was no documentation indicating the stage of the wound or where the wound was located on R2's sacrum. There was no documentation assessing the peri-wound (area around wound) they either drew a line through the area for the peri-wound assessment on the sheet or documented yes or no. This wound was documented as being healed on 10/25/10. 2. Review of the clinical record and wound sheet revealed R4 had a wound on the scrotum. The wound was not consistently measured, it was never staged and for the description of the peri-wound there was consistent documentation of "yes". This wound was documented as being healed on 11/4/10. On 11/9/10 and 11/10/10 interviews were conducted with five (5) E3, E4, E5, E6, and E7 (LPNs on staff for the facility) concerning wound assessment documentation. All five of the nurses	**§483.25(c)** 1) A mandatory in-service was held on December 29, 2010 for the nurses. This in-service was given by Joanne Shirey from WOCN Consultation Services. She gave an in depth training on how to measure and document wounds and also how to stage a wound. Please see attachment #5. The in-service covered documenting the stage of the wound and where it is located. They were also in-serviced on assessing the peri-wound and the meaning of peri-wound. The nurses are to report all new wounds to the DON. The DON will monitor that nurses are documenting wounds according to policy. 2) The in-service on December 29, 2010, instructed the nurses on how to measure the wound, stage the wound and how to correctly document the peri-wound area. During this in-service, the meaning of peri-wound was also taught. See attachment #5. The nurses are to report all new wounds to the DON. The DON will monitor that nurses are documenting wounds according to policy.

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	stated they did not know how to stage or measure a wound. All five of the nurses were asked the meaning of peri-wound. All five of the nurses stated it meant whether or not the wound was located in the peri-area. All five of the nurses indicated they needed education on wound care. Review of the interview conducted with 1/3 of the facility's LPN staff with the E2 (DON) on 11/11/10 at 9:35AM revealed the facility had training on wound care however; the nurses that were educated left the facility. 3. R1 was admitted to the facility on 4/20/10 with at Stage IV pressure ulcer. The facility policy and current standards of practice required the assessment of skin/pressure ulcers to be done on a weekly basis. There were no measurements documented between 4/25/10 and 5/12/10. The resident was readmitted to the facility on 8/16/10 after an extended hospital stay. There were no wound measurements between 8/16/10 and 9/7//10. This was confirmed by interview with the DON E2 on 11/8/10. **§483.25(h) Accidents** **The facility must ensure that –** **(1) The resident environment**	3) Our policy of weekly skin assessments was reviewed at the nurses meeting on January 24, 2010 and the nurses were instructed on how to properly complete these forms at the in-service on December 29, 2010. Please see attachment #6. The DON will review the skin sheets on a monthly basis to ensure that the nurses are properly assessing and documenting wounds. The nurses have been instructed that when a wound is not responding to treatment, they are to notify the DON for her to evaluate and notify the facility's wound consultant for a consult

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	remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. **This requirement was not met as evidenced by:** Based on observation and interview it was determined that for 2 (R10 and R11) out of 12 sampled residents the facility failed to maintain an environment free from an accident hazard when medications were left unattended. Findings include: 1. On 11/9/10 at 7:02 AM E4 (LPN) was observed providing care for R10 (female resident). In the bed across from R10 was R11 (male resident) lying in the bed talking to us. E4 stated R11 had Alzheimer's dementia and was a wonderer. E4 continued to state that there several residents that are wanderers living in the facility. R11 was not R10's husband. On the bedside table beside R10's bed was a blister package of Metoprolol (Beta Blocker used for the treatment of high blood pressure) 50 mg with 5 tablets left. E4 was observed going out of the room to get items off the medication cart located in the hallway. E4 left the Metoprolol on the bedside table unattended and within reach of R10 and R11. At the completion of the care, E4 left the room and went to the medication cart located in the hallway. The	**§483.25(h)** At the nurses meeting on January 24, 2010, the nurses were instructed that they are never to leave medications unattended in resident's rooms and their medication carts are to be locked at all times when unattended or out of vision of the nurse. A note has been posted at each nurse's station as a reminder that they are not to leave medications in resident rooms and their carts are to be locked at all times when unattended or out of view. The DON will monitor that the nurses comply.

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	medication cart was left unlocked, unattended and out of vision while E4 was providing care to R10. **§483.65 Infection Control** **The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.** **§483.65(a) Infection Control Program** **The facility must establish an Infection Control Program under which it –** **(1) Investigates, controls, and prevents infections in the facility;** **(2) Decides what procedures, such as isolation, should be applied to an individual resident; and** **(3) Maintains a record of incidents and corrective actions related to infections.** **§483.65(b) Preventing Spread of Infection** **(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.** **(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.**	

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	(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. **This requirement was not met as evidenced by:** Based on observation, interview and review of the facility's policy and procedures it was determined that the facility failed to ensure staff washed their hands after the removal of gloves. Findings include: Review of the facility's policy and procedure for hand washing revealed "Hands should always be washed after removing gloves." 1. On 11/9/10 at 7:02 AM E4 (LPN) was observed providing care to R10's peg site. E4 donned gloves to assess peg tube placement. E4 cleaned the stoma area and replaced the drainage gauze. E4 removed her gloves, filled a cup with water, donned another pair of gloves without washing her hands then began administering a protein supplement to R10. Review of the incident with E4 confirmed she forgot to wash her hands after removing her first pair of gloves. 2. On 11/9/10 at 1:05 PM E3 (LPN) was observed providing wound care to R8's heel wounds. E3 donned gloves to remove R8's slippers, then removed the dressings, cleaned the wounds on	**§483.25(h)** The policy and procedure for hand washing between glove changes and when leaving a resident's room was reviewed at the January 24, 2011 meeting. The staff was reminded to wash hands every time gloves were removed. The staff were also encouraged to remind other staff when improper hand washing was noted. The DON will monitor staff for proper hand washing when gloves are removed and the nurses are expected to observe the C.N.A.'s for proper hand washing and glove use.

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	both heels and prepared the new dressings to apply on the wounds. E3 removed her gloves to apply the clean dressing and donned new gloves without washing her hands. Review of the incident with E3 confirmed the surveyor's observation. 3. On 11/10/10 at 3:00 PM E11 (CNA) was observed taking a linen cart from a resident's room to the next hallway to empty the linen cart wearing gloves. E11 emptied the cart went back to the other hallway and removed her gloves. E11 then started to go into another resident's room. This observation was done with the surveyor and two LPNs (E4 and E5). The LPNs stopped E11 from going any further until she washed her hands. Review of the incidents with E2 DON on 11/12/10 at 11:00 AM revealed the staff came to her and told her about the observation. E2 continued to state that the staff is very aware of their errors with hand washing and glove use.	3). E11 was in-serviced on the policy and procedure for hand washing between glove changes. The policy and procedure was also reviewed at the nurses meeting on January 24, 2011. The DON will monitor staff for proper hand washing when gloves are removed and the nurses are expected to observe the C.N.A.'s for proper hand washing and glove use.
3201.6.3.7	**The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.**	

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	This requirement was not met as evidenced by: Based on record review and interview it was determined that for 2 (R2 and R4) out of 12 sampled residents the facility failed to revise the care plan when changes in care were initiated or discontinued. For 1 (R3) out of 12 sampled residents the facility failed to conduct a yearly comprehensive assessment. Findings include: Review of the facility's "Interdisciplinary Care Plans" policy stated "Objective-Care plans are to be within 7 days of admission, updated when problems occur or are resolved, reviewed at care plan meeting every 60 days." Review of R2's care plans revealed the following: 1a. Review of R2's current care plan dated 9/27/10 for altered skin integrity documented under approaches "Duoderm change every 3 days". Review of the wound sheets revealed the wound was healed on 11/8/10. b. Review of R2's current care plans dated 9/27/09 for Insomnia, anxiety/agitation, pain and hypertension documented under approaches various po (by mouth) medications. Review of R2's clinical record revealed all R2's po medications were discontinued on 10/16/10 due to R2 refusing to take po medications.	**3201.6.3.7** 1a) At the nurse's meeting on January 24, 2010, the nurses were instructed that if a resident has a change in status or treatments, they are to update the careplan or notify the DON of the change in status for her to update the careplan. The DON will monitor that these updates are being done as change occurs. b) At the nurse's meeting on January 24, 2010, the nurses were instructed that if a resident has a change in status or treatments, they are to update the careplan or notify the DON of the change in status for her to update the careplan. The DON will monitor that these updates are being done as change occurs. Please see attachment #7 for updated careplan.

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	c. Review of R2's current care plan dated 7/21/09 for Urinary Tract Infection documented under approaches "Cath. resident every morning before breakfast and every evening at bedtime." During the survey observations were made of R2 and review of R2's clinical record was completed both revealed R2 had a foley catheter inserted continuously to drainage due to urinary retention.	c) At the nurse's meeting on January 24, 2010, the nurses were instructed that if a resident has a change in status or treatments, they are to update the careplan or notify the DON of the change in status for her to update the careplan. The DON will monitor that these updates are being done as change occurs. Please see attachment #7 for updated careplan.
	2. Review of R4's current care plan documented "Depression as evidence by (circle those that apply) wanting to go home, anxiety, irritable, agitation, appetite loss, weight loss, suicide comments, pessimism, delusions also has some paranoia thoughts and anger." R4's care plan was reassessed on 8/1/10 and again on 10/5/10. Documentation evaluating this care plan stated "no indication of depression". Review of R4's clinical record revealed he was administered Ativan for agitation nine times in August 2010 and 4 times in September 2010. The facility failed to identify R4's need for Ativan due to his agitated behaviors.	2). R4 is also care planed for Potential Chronic UTI's with symptoms of increase in behaviors. The careplan was updated to "check urine for UTI when resident becomes anxious, irritable or agitated." Please see attachment #8. Nurse's notes reveal that R4 had a Urinalysis and C&S done on August 15, 2010 with positive results. At the nurse's meeting on January 24, 2010, the nurses were instructed that if a resident has a change in status or treatments, they are to update the careplan or notify the DON of the change in status for her to update the careplan. The DON will monitor that these updates are being done as change occurs.
	Review of R2's and R4's care plan with E2 (DON) on 11/12/10 at 9:25 AM confirmed they were not revised when there was a change in the plan of care.	
	3. R3's most recent comprehensive assessment was dated 3/2/09. An interview with the DON E2 on 11/9/10	3). R3 had two comprehensive assessments on the chart. The first one was dated 3/2/09 but the second one was not dated. This one would have been scheduled to be done in February 2010 and was completed between February and April 2010. Please see attachment #9. A new system for

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	revealed that no other assessment could be found for R3 and all residents should have initial and annual assessments.	tracking the comprehensive assessments has been initiated. In the future, the medical secretary will schedule the assessments to be done on admission and annually and will monitor that all forms are returned in a timely manner. The DON will review all forms for completion, dates and accuracy.
3201.6.9.4.1	**All employees shall receive education and training on standard precautions, use of personal protective equipment, the importance of hand hygiene, the facility's infection control policies and reporting of exposures to blood or other potentially infectious materials.** **This requirement was not met as evidenced by:** Based on record review and staff interview, it was determined that the facility failed to ensure that all staff were trained for infection control practices. Findings include: Five (5) out of thirteen (13) employees, who had been employed for more than a year, had no current infection control training listed in the records.	**3201.6.9.4.1** We are currently in the process of updating our records to ensure that all staff have had training on infection control within the last year and will have this completed by March 1, 2011. In the future, infection control training will be completed at time of hire for new employees and all staff will need to complete a training for infection control before receiving their yearly evaluation. The medical secretary will keep a record of staff needing to complete infection control training prior to having their evaluation completed. Please see attachment #10.
3201.6.9.6	**The facility shall contract with a licensed pest control vendor to ensure that the entire facility is free of live insects and other vermin.** **This requirement was not met as evidenced by:** Based on observations throughout the building during the entire survey, it was determined that the facility failed to	

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	ensure that the pest control vendor kept the facility pest free. Findings include: Numerous fly observations were made in multiple locations including dining, resident rooms, and common areas through out the survey.	**3201.6.9.6** In the past, we have enclosed some of the entrances and this seemed to make a noticeable difference in those areas. We plan to enclose the entrance off the dining area and install a fan above the door in the front entrance. This will be completed by May 1, 2011. We will also speak with our pest control company about spraying the outside entrances for flies. The administrative assistant will monitor that these are completed on time.
3201.6.13.1.6	**The infection control committee shall establish the infection control training of staff and volunteers, and disseminate current information on health practices.** **This requirement was not met as evidenced by:** Based on record review and staff interview, it was determined that the facility failed to ensure that all staff were trained for infection control practices. Findings include: Five (5) out of thirteen (13) employees, who had been employed for more than a year, had no current infection control training listed in the records.	**3201.6.13.1.6** We are currently in the process of updating our records to ensure that all staff have had training on infection control within the last year and will have this completed by March 1, 2011. In the future, infection control training will be completed at time of hire for new employees and all staff will need to complete a training for infection control before receiving their yearly evaluation. The medical secretary will keep a record of staff needing to complete infection control training prior to having their evaluation completed. Please see attachment #10.
3201.8.4	**The staff on all shifts shall be trained on emergency and evacuation plans.** **This requirement was not met as evidenced by:** Based on record review and staff interview, it was determined that the facility failed to ensure that all staff were trained for infection control	

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	practices. Findings include: Four (4) out of thirteen (13) employees, who had been employed for more than a year, had no current infection control training listed in the records.	**3201.8.4** We are currently in the process of updating our records to ensure that all staff have had training on our emergency and evacuation plans within the last year and will have this completed by March 1, 2011. In the future, emergency and evacuation training will be completed at time of hire for new employees and all staff will need to complete a training for emergency and evacuation plans before receiving their yearly evaluation. The medical secretary will keep a record of staff needing to complete the emergency and evacuation training prior to having their evaluation completed. Please see attachment #10.
3201.9.5	**Incident reports, with adequate documentation, shall be completed for each incident. Adequate documentation shall consist of the name of the resident(s) involved; the date, time and place of the incident; a description of the incident; a list of other parties involved, including witnesses; the nature of any injuries; resident outcome; and follow-up action, including notification of the resident's representative or family, attending physician and licensing or law enforcement authorities, when appropriate.**	
3201.9.6	**All incident reports whether or not required to be reported shall be retained in facility files for three years. Reportable incidents shall be communicated immediately, which shall be within eight hours of the occurrence of the incident, to the Division of Long Term Care Residents Protection. The method of reporting shall be as directed by the Division**	
3201.9.8	**Reportable incidents are as follows**	

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3201.9.8.4.2	**Injury which results in transfer to an acute care facility for treatment or evaluation or which requires periodic neurological reassessment of the resident's clinical status by professional staff for up to 24 hours.** **This requirement was not met as evidenced by:** Based on record review and interview it was determined that for 1 (R5) out of 12 sampled residents the facility failed to complete an incident report and failed to report a reportable incident to the state agency. Findings include: 1. Review of nurses' notes documented that on 2/8/10 at 6 am R5 was found on the floor in his room with a facial injury and bleeding to the nose. The resident was sent to the emergency room (ER) for evaluation. The resident returned to the facility at 11:15 am and neurological checks were conducted by nursing staff. An interview with the DON E2 on 11/9/10 revealed that there was no incident report available for this fall regarding an injury that required medical attention. Review of the state data base revealed that the incident was not reported to the state agency. There was no evidence that a thorough investigation was conducted of this unwitnessed fall with injury. Review of the facility's policy for	**3201.9.8.4.2** At the nurses meeting on January 24, 2011, the nurses were instructed that they need to complete an incident report for all falls and that all reportable incidents are to be reported to the Division of Long Term Care Residents Protection. Also, a thorough investigation needs be done for all unwitnessed falls with injury. The facility's policy has been updated to include the regulatory requirements to report injuries that require neurological checks and/or emergency room assessment and should be immediately reported to the state agency. See attachment #11. The DON will monitor that incident reports are completed on all falls and reported to the state in a timely manner.

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	completing incident reports stated that an incident report should be completed on all falls. The policy lacked the regulatory requirements to report injuries that require neurological checks and/or emergency room assessment should be immediately reported to the state agency.	
Title 16 Chapter 11, §1162 (a)	**Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement was not met as evidenced by:** Based on observations throughout the building on 11/10/10, it was determined that not all staff were wearing nametags. Findings include: 1. Three C.N.A.'s on the new wing, E12, E13, and E14 were observed to be working, walking in and out of resident rooms, with no visible nametags displayed. 2. A C.N.A. working on the old unit, E8,was observed to be working with no visible name tag. 3. An ancillary staff member, E15, was observed working with residents and had no visible name tag.	**Title 16** **Chapter 11, §1162 (a)** Staff have been reminded that name tags need to be worn at all time and to request a replacement if they have misplaced theirs. A sign-up sheet for replacement name tags has been posted to ensure that all staff have a name tag including the maintenance staff. In the future, the administrative assistant will monitor that all staff are wearing a visible name tag while on duty.

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	4. Maintenance staff, E16, was observed to be working on the new unit and around the building with no visible name tag.	
Title 16 Chapter 11, §1121 (1)	**Patient's Rights** **Every patient and resident shall have the right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.** **This requirement was not met as evidenced by:** Based on observation and interview it was determined that the facility failed to treat residents in manner that respected their dignity and individuality. Findings include: 1. Observation during lunch on 11/8/10 revealed that meals were served to all residents in the dining room with their plates left on cafeteria trays. 2. On 11/8/10, a lunch observation was conducted on the Rose Garden Unit from 11:50 AM through 12:30 PM. Residents were observed sitting in chairs around the parameter of the room eating on over the bed tables or TV dinner trays. Two CNAs were	**Title 16** **Chapter 11, §1162 (a)** 1). Cognitively alert residents are now given the choice if they would like to have their meals served on cafeteria trays or served without the tray. The nurses will monitor that this choice is being offered to the residents. 2). The residents are now given the choice if they would like to sit at the dining room table or remain in their chairs and eat from a table. When a resident, who is sitting at the dining table, has completed their meal, the tray will be removed from the table instead of pushing it to the center. The nurses will monitor that this choice is being offered to the residents and trays are removed as needed.

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	observed assisting four residents (R13, R14, R15, and R16) eating. R9 was observed sitting in a recliner around the parameter of the room with the rest of the residents without food. At 12:15 PM, one of the residents being assisted with feeding was finished eating. E10 (CNA) removed the resident from the chair and pushed the empty plate to the center of the table. E10 then placed R9's tray on the table, moved R9 up to the table and began assisting her with eating. E8, E9 and E10 (CNAs) were observed using the residents food protectors to wipe the residents mouths instead of using napkins. The facility failed to provide a dignified dining experience.	The staff has been instructed to use a napkin to clean a resident's face after meals instead of with the food protectors. The nurses will monitor